

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/30/2015
NAME OF PROVIDER OR SUPPLIER SAINT ANNE COMMUNITIES AT BISHOP LUERS		STREET ADDRESS, CITY, STATE, ZIP CODE 5610 NOLL AVE FORT WAYNE, IN 46806		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: December 30, 2015</p> <p>Facility number: 001150 Provider Number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 13 Total: 13</p> <p>Census payor type: Other: 13 Total: 13</p> <p>Sample: Residential sample: 7</p> <p>Saint Anne Communities at Bishop Luers was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>QR completed on December 30, 2015 by 17934.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE